SCHIP Reauthorization and Financing: Issues in the Current Debate

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INTRODUCTION

Reauthorization of the successful State Children's Health Insurance Program (SCHIP) is a major health policy topic this year. This health insurance program for low-income children has been credited with reducing the rate of uninsured children in the United States at a time when health care costs have been rising well beyond the rate of inflation and there was an economic recession. The program is set to run out of new money on September 30, 2007 unless Congress acts to extend it.

California has the largest SCHIP program in the nation, known as the Healthy Families Program (HFP). In 2006 alone, the state spent more than $1 billion in federal SCHIP dollars; and over the past 10 years, California has spent more than $5 billion federal SCHIP dollars to provide health coverage to children. Federal contributions through SCHIP provide about 65 percent of the funding needed to operate HFP in California, which today covers about 800,000 children. Clearly, SCHIP funds play a critical in supporting California's health care system.

PURPOSE OF THIS ANALYSIS

This paper is second in a series sponsored by the California HealthCare Foundation examining California's stake in the current SCHIP reauthorization debate.[1] This paper offers an environmental scan of SCHIP program issues that will likely arise during the forthcoming debate, including possible policy changes to eligibility and benefits rules. Far from being an inventory of all issues, this paper focuses on those issues that could have a significant impact on California.

BACKGROUND

SCHIP, authorized under Title XXI of the Social Security Act, was created in the Balanced Budget Act (BBA) of 1997 to serve "targeted low-income children," defined as uninsured children under age 19 in families with incomes below 200 percent of the Federal Poverty Level (FPL) ($34,340 for a family of three in 2007).[2] Congress allocated $39.6 billion over 10 years to the program, making it the largest expansion of public health insurance since the creation of Medicare and Medicaid in 1965. The legislation gave states significant flexibility in designing SCHIP programs and the federal government has allowed some program expansions through waivers. To implement SCHIP, states could choose to expand their existing Medicaid programs (called Medi-Cal in California), create a new children's insurance program, or opt for a combination of both.[3]

California chose a combination expansion. It initiated a small coverage expansion under Medicaid by increasing Medi-Cal eligibility for children ages 6 to 18 with family incomes between 85 and 100 percent of FPL, and it created a separate program for children with incomes above Medi-Cal levels, known as the Healthy Families Program (HFP). California also uses SCHIP funds to enhance and support improvements to Medi-Cal that promote children's health insurance, as well as to support prenatal care. The Managed Risk Medical Insurance Board (MRMIB) oversees HFP.

SUCCESS OF THE SCHIP PROGRAM

In the United States, health insurance coverage promotes access to care and improves a child's chances of reaching full physical and mental health potential.[4] To this end, SCHIP has been successful in decreasing the number of uninsured children nationally. The estimated number of uninsured, low-income children nationwide decreased from nearly 23 percent in 1997 to 15 percent in 2003, despite a national economic recession that resulted in many families losing access to employer-based health insurance coverage.[5] By 2005, the national uninsured rate for children had fallen to 12 percent. California had a similar experience, with a rate of uninsured children falling from 21 percent in 1998 to 14 percent in 2005.[6]

REAUTHORIZATION BILLS IN CONGRESS

Two major bills have been proposed that would comprehensively address SCHIP reauthorization[7]:

- *The Children's Health First Act* (S.895/H.R. 1535) is sponsored by Representative John D. Dingell (D-MI) and Senator Hillary Rodham Clinton (D-NY). Introduced on March 15, 2007, the bill intended to represent a more global approach to achieving comprehensive children's health coverage and therefore includes more sweeping principles in addition to some specific provisions related to SCHIP.

- *The CHIP Reauthorization Act of 2007* (S. 1224) is sponsored by Senators Jay Rockefeller (D-WV), Olympia Snowe (R-ME), and Edward Kennedy (D-MA). Introduced on April 27, 2007, the bipartisan Rockefeller-Snowe is intended to address SCHIP reauthorization exclusively and will likely be used as the basis for the Senate "mark up" of the bill.

REAUTHORIZATION ISSUES TO CONSIDER

There are many important issues related to SCHIP reauthorization that will impact California and could be addressed through either of these bills. The most basic issue is determining California's need for federal funds, which has been estimated between $6.7 billion and $8.1 billion over the next five years just to cover uninsured children already eligible for HFP.[8] Yet, that is just one part of the story. Assuming the federal allotment is increased beyond levels required to maintain existing coverage, policymakers will face important questions about potential programmatic changes. While the technical financing issues are addressed in a forthcoming document, this paper addresses these potential programmatic changes relevant to California with respect to two broad policy categories:

- Eligibility Rules: Who could be covered under SCHIP?
- Benefits and Cost-Sharing: What could be allowed and required under SCHIP?

ELIGIBILITY RULES: WHO COULD BE COVERED UNDER SCHIP?

There is an active debate on whether SCHIP eligibility rules should be changed. Some have called for SCHIP to be a vehicle for universal coverage for children, such as Medicare is for people 65 and over. Others believe that SCHIP funds should be focused only on lower-income children. This section discusses what impact potential eligibility changes at the federal level could have on California.

Possible Eligibility Expansions. Some states, as well as children's health advocates, have made it clear that they would like to see SCHIP as a vehicle for further coverage expansions. An expansion would be welcome in many states as part of health reform plans, including bipartisan plans in California, focus on using SCHIP as a step toward achieving universal coverage for children.[9] Eligibility expansion options include covering:

- *Children to higher income levels.* Today, eight states cover children up to 300% of poverty and higher through the use of waivers and other expansion methodologies (such as income disregards) and many states would clearly like to have the opportunity to receive SCHIP funds for such coverage.[10] Congress could streamline SCHIP's eligibility rules by explicitly changing the statute to include children at higher income levels.

  The Dingell-Clinton bill encourages states to expand SCHIP coverage to families with incomes up to 400 percent FPL (nearly $70,000 for a family of three in 2007), essentially providing a state entitlement to federal SCHIP funds. The Rockefeller-Snowe proposal would expand SCHIP funding and permit states to extend coverage to families with incomes up to 300 percent FPL ($51,500 for a family of three in 2007).[11]

  For California, both of these proposals are consistent with the state's efforts to use county programs trying to cover additional children. In 2001, the California Legislature expanded the use of SCHIP funds by establishing the County Health Initiative Matching (CHIM) Fund program. Through this program, three counties (Santa Clara, San Mateo and San Francisco) leverage local funds to draw down some of the unspent portion of California's federal SCHIP allotment according to the same 2-to-1 matching rate used by the state. On a county-by-county basis, HFP is expanded to uninsured children living in families earning incomes between 250% and 300% FPL. If California covered children up to 300% FPL, the state could receive $500 million in federal SCHIP dollars over the next five years, if all eligible children were enrolled.[12]

- *Older Children.* Another possibility for expanding children's coverage would be to permit states to enroll children up to age 21 in SCHIP, as they are permitted to do in Medicaid. SCHIP eligibility rules under current law give states the opportunity to receive SCHIP funds for covering children up to age 19 with family incomes too high to qualify for Medicaid, but generally too low to afford private coverage. Many states have elected this option under Medicaid and would like to be able to receive SCHIP funds to do so as well. Currently, this option is not included in either the Dingell-Clinton or the Rockefeller-Snowe proposals.

- *Pregnant Women.* California is one of six states that received a federal waiver to use SCHIP funds to cover pregnant women (the Access for Infants and Mothers Program). This concept, and the importance of prenatal care, was envisioned under the original SCHIP statute, but Congress could go one step further and explicitly include coverage of pregnant women as an optional eligibility group under SCHIP. Both the Rockefeller-Snowe and the Dingell-Clinton proposals include such options explicitly without need for

a waiver. This both simplifies things administratively and would guarantee federal funding for this population into the future.

- *Legal immigrants under the five year ban.* Under the 1996 welfare reform law, no legal immigrants are eligible for federal support under Medicaid and SCHIP until they have been in the country for at least five years. This lack of federal funds creates a barrier for states to provide coverage to this population. Both Rockefeller-Snowe and Dingell-Clinton include an explicit option for states to provide coverage to legal immigrant children and pregnant women in Medicaid and SCHIP. Like many states, California uses state-only funds to cover 15,300 children who are otherwise eligible for HFP but prohibited from using federal funds by the five-year ban.[13] It is worth noting that any change to the five-year ban will have a much greater financial impact on Medicaid than SCHIP, as greater numbers of otherwise ineligible children would become eligible for Medicaid than SCHIP.

- *Parents.* Both the Clinton administration and the Bush administration granted waivers to cover adults under SCHIP. The original SCHIP law envisioned the possibility of covering parents of children enrolled in SCHIP.[14] One reason frequently given to use SCHIP dollars for adult coverage is that covering adults has proven to increase enrollment and coverage of children.[15] The federal government has allowed 12 states to cover adults (parents and/or childless adults) and six states to cover prenatal care. However, some policymakers, particularly conservatives, say that using SCHIP funds to insure adults, especially those without SCHIP-eligible children at home, is contradictory to the program's original legislative intent. In addition, the previously Republican-controlled Congress passed the Deficit Reduction Act of 2005 (DRA), which prohibits new SCHIP waivers from covering childless adults.

  California received permission from the federal government to use SCHIP dollars to cover parents of children enrolled in HFP in 2002. The state never implemented the waiver due to a lack of state funding,[16] and now the waiver option has expired. Though no current estimates exist on the impact of covering adults in California through SCHIP, federal flexibility here could assist California in its efforts at extending health coverage to uninsured adults.[17]

Possible Reductions in Eligibility Levels. President Bush's budget calls for SCHIP to "refocus" SCHIP funds on children with incomes at or below 200% FPL, the so-called "core population" because it is named in law as the target population for SCHIP. However, 16 states, including California, cover children above this level.[18] In addition, many states whose SCHIP plans indicate an eligibility level of 200 percent of the FPL actually cover children to much higher income levels through the use of income "disregards". The use of disregards changes a state's "effective" income eligibility level and could be an issue for many states if the Administration chose to interpret the statute strictly.

Today, California covers about 190,000 children between 200% and 250% of the FPL.[19] The president's preferred policy clearly puts coverage of these children at risk. In addition, California is one of several states that use the federal option to direct SCHIP funds towards

prenatal care programs, with 7,600 pregnant women receiving services during March 2007. The possible impact of the president's policy on the prenatal population is unclear. While it seems unlikely that the Democratic Congress would accept the president's proposal, this change would be a significant point of contention for certain states.

Outreach Funding and Enrollment Incentives. One of the stated priorities of both the Bush administration and the policy community is to refocus efforts on reaching the 6 million children who are eligible for public programs but are currently uninsured. As part of SCHIP reauthorization, Congress has the opportunity to include additional funding specifically for outreach, as well as provide states with fiscal incentives to increase enrollment of eligible children.

Both bills address this issue by devoting new resources to outreach, and by including several incentives for states that could increase enrollment. Under the Dingell-Clinton proposal, states that adopt eligibility simplification and outreach strategies can earn an increase in the matching rate paid by the federal government. These new incentives will undoubtedly assist California in reaching its goal of universal coverage for children, but counting those children who are eligible but not yet enrolled will be a key to the budgeting process.

Among several outreach options, the Rockefeller/Snowe bill creates federal authorization for California's own "Express Lane" eligibility, giving states the option to expedite eligibility using the financial information gathered from other publicly funded programs, such as the school lunch program. For those states that make significant progress toward insuring all children, an enhanced Medicaid matching rate (enrollment bonus) would be available when states meet certain milestones.[20]

California's funding for outreach was eliminated in 2003 due to state budgetary constraints, but was fully restored in 2006. About half of the uninsured children in California are eligible for Medi-Cal or HFP.[21] Given this, new incentives to cover additional children could be very important to California. California would benefit from dedicated outreach funding and additional state and federal support.

Citizenship Requirements. Under the DRA, children applying for Medicaid (including SCHIP-funded Medicaid expansions), must provide documentation of citizenship and identity.[22] Although some policymakers argue that these rules are needed to prevent fraud, these measures conflict with state eligibility and enrollment simplifications efforts. Evidence already exists that this new requirement is reducing Medicaid enrollment in specific states.[23]

By expanding the use of the DRA rules to non-Medicaid SCHIP programs, Congress would increase barriers to enrolling California children into HFP.[24] For example, the use of the California Joint Application mail-in form for Medi-Cal and HFP, as well as electronic enrollment processes, would both be much less efficient under DRA. And requiring presentation of an original birth certificate may even be a de-facto requirement for a face-to-face interview of applicants' parents, if those parents are unwilling to send an original birth certificate through the mail. Both bills address this issue by giving states discretion on citizenship issues.

Simplification of Crowd-Out Requirements. SCHIP requires states to establish rules that discourage parents and employers from dropping employer-sponsored insurance in favor of state-subsidized insurance (a process generally referred to as "crowd-out"). By simplifying federal crowd-out rules, HFP could encourage enrollment of uninsured children. When crowd-out occurs in this context, the government pays the cost of covering children who previously had coverage paid for by employers. As most of the specific rules governing crowd-out were developed through federal regulation, Congress could choose to simplify enrollment and give states more discretion to construct their own programs. Historically, the research as to whether or not crowd-out occurs in SCHIP has been mixed. However, the Congressional Budget Office recently found that 25 to 50 of every 100 children enrolling in SCHIP had left private insurance.[25] Additional state flexibility on crowd-out rules could ease barriers to enrolling more California children in HFP.

California requires that children enrolling in HFP do not have employer-sponsored health insurance for three months prior to enrollment.[26] There are few exceptions to this rule, which are based on federal requirements. This policy is a barrier to enrollment and lengthens the HFP application. Also, the crowd-out policy complicates the Governor's individual mandate proposal under health reform. Families dropped from an employer's coverage would be required to purchase insurance immediately on the individual market or through the purchasing pool, even though their children may be eligible for HFP within three months. In this scenario, those children could potentially have three different health plans within a four-month period. The administrative costs alone, not to mention the burden of enrollment and disenrollment, warrant reconsideration of this policy at the federal level.

BENEFITS AND COST-SHARING: WHAT COULD BE ALLOWED AND REQUIRED UNDER SCHIP?

Under the SCHIP law, states must offer program enrollees health insurance that meets a set benchmark standard or that receives approval from the US Secretary of Health and Human Services. Throughout the program's operation, states have sought greater flexibility in benefits and cost-sharing. For example, health advocates have called for additional benefits and reduced cost-sharing, especially for special needs children. Currently, states have considerable flexibility over SCHIP benefit design. Policymakers will have the opportunity to revisit several of these issues during SCHIP reauthorization.

Premium Assistance and Preventing Crowd Out. Some low-income parents are offered employer-based insurance for their children that is comparable to the SCHIP benchmark, but they do not enroll because they find it unaffordable or for other reasons. One way to increase coverage of children and parents is to use SCHIP funds to create a premium assistance program to help working parents take advantage of their employer's benefits. Under a premium assistance approach, states could provide funds to support the family contribution for children. This approach keeps the family together in the same health plan, and it helps defray public costs by partnering with the employer.

Premium assistance was a key part of the bipartisan support for SCHIP in 1997. The Republican Caucus believed that the new program should not provide incentives for employers to drop health insurance coverage for their workers.

As part of its unimplemented Section 1115 waiver approval to cover parents under SCHIP, California was required to conduct a feasibility study to see whether premium assistance was a viable option in the state. California's study indicated several implementation barriers, including limited availability of employer sponsored insurance for low-wage workers, rapidly rising premium and cost-sharing requirements, and a variety of other administrative challenges.[27]

Both of the SCHIP bills under discussion include some streamlining of rules regarding public-private interactions that are intended to strengthen ties to the private group health insurance market.[28]

Wrap-Around Services for the Underinsured. The SCHIP statute bars states with SCHIP programs separate from their Medicaid program from offering services to augment the coverage of children with privately obtained coverage because children with "credible coverage" (essentially any child enrolled in any other health insurance) are excluded from program enrollment.[29] At the same time, states with SCHIP expansions through Medicaid can provide wrap-around coverage to children with less comprehensive private insurance.[30] The Medicaid statute does not bar children with "credible coverage" and has explicit provisions for how the program can wrap around other coverage.[31] However, the current process for states with non-Medicaid SCHIP to provide wrap-around coverage is extremely complicated and involves detailed actuarial requirements. By bringing the separate SCHIP rules in line with the Medicaid rules, states could improve the coverage provided to children while sharing the cost of child health insurance with employers. By allowing greater use of wrap-around services as is proposed under both bills, the federal government would give California (a state with a non-Medicaid SCHIP expansion) new flexibility to cover children. Under this approach, children with employer-sponsored insurance could continue to receive those benefits, and access certain HFP covered services that are lacking in the employer benefit plan, such as dental or vision insurance.

Possible Requirement to offer EPSDT in SCHIP. The current SCHIP benefit package rules allow flexibility for states to determine the benefits to offer SCHIP enrollees. In an attempt to make SCHIP more like a commercial insurance plan, the law gives states four benefit package options to choose from. There has been some discussion of including Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) from Medicaid in the standard SCHIP benefits package.[32] EPSDT is a mandatory service for all categorically needy individuals under age 21 who are enrolled in Medicaid, but is not required in SCHIP. Federal law defines EPSDT to cover certain 'screening,' 'diagnostic,' and 'treatment' services, which must be furnished to eligible children, both at age-appropriate periodic intervals and as needed.[33] Advocates have raised concerns over substandard benefits in SCHIP and out-of-pocket costs that limit access to care, particularly to vulnerable populations.[34] By requiring EPSDT in SCHIP, the federal government would ensure children access to benefits that are more comprehensive than those offered today. However, this would conflict with the goal for SCHIP to be flexible and based on a private insurance model.

California has worked to offer a full benefit package, including mental health and disability needs. While a requirement to offer EPSDT services may improve the benefits of HFP to California children, no analysis has been done to determine the cost impact of this specific proposal on the states. One unintended consequence of creating a more expensive benefit package could be to force California to save money elsewhere in the program—with possible steps including capping enrollment. Before taking a position on this policy, it is critical to know the financial impact on the state.

Chronic Care Programs. Disease management and case management are approaches not specifically mentioned as part of the required SCHIP benefits. The federal government could allot funds for chronic care disease management programs to help families with chronically ill children better manage their health. For children with chronic conditions, such as the growing number with the twin conditions of obesity and diabetes, disease and/or case management services can be important for improving care, quality of life, and containing costs.

In California, managed care plans serve as the primary care delivery system for the vast majority of HFP children, though it is unclear what chronic services maybe offered. Also, the California Children's Services (CCS) program offers support to those children with long-term needs. Congress could choose to make additional resources available to states with the specific goal in mind of promoting disease management tools that could reduce costs.

CONCLUSION

Broadly considered a success, SCHIP makes critical contributions to children's health care in the United States. It gives children the chance to be healthy.[35] As the federal SCHIP debate continues, decisions surrounding the policy issues raised in this paper could determine a new direction for SCHIP.

The challenges of expanding and improving children's health insurance are serious but surmountable, as proven by the original passage of SCHIP. Regardless of the outcomes, the debate over SCHIP reauthorization will offer an opportunity to reassess health coverage priorities and approaches. The balance of federal and state governance, the relative roles of public and private insurers, the definition of coverage, and the public's willingness to pay for results will be reviewed, argued, and potentially resolved in SCHIP reauthorization. This will not only affect the health insurance coverage for millions of low-income children, but will inform future debates over improving the coverage system for all Americans.

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About the Foundation
The California HealthCare Foundation, based in Oakland, is and independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care.

About the CHCF SCHIP Reauthorization Project
This is the second paper of a three paper series designed to educate policymakers on California's policy issues related to the 2007 reauthorization of the State Children's Health insurance program. This first paper, published in March 2007, examined California's needs for future SCHIP allotments based on spending projections. The third and final paper, forthcoming in June 2007, will examine specific factors of the proposed SCHIP allotment formula and their impact on California.

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[1] The first paper, "Funding California's SCHIP Coverage: What Will it Cost?" offered an analysis of California's SCHIP budget need over the next five years. The third paper will also address budget issues directly by considering possible changes in the formula used by SCHIP to allocate funds to state programs.
[2] States that had already expanded coverage had the option to expand coverage to the highest of 200% FPL or to 50 percentage points above their pre-SCHIP coverage levels. States also have the authority to use "income disregards" to expand coverage levels.
[3] Jennifer Ryan, "SCHIP: The Basics," National Health Policy Forum. March 27, 2007. Available at: http://www.nhpf.org/pdfs_basics/Basics_SCHIP.pdf
[4] P. Newacheck, J. Stoddard, D. Hughes, & M. Pearl, *Heath insurance and Access to Primary Care for Children*, New England Journal of Medicine, 338: 513-519 (1998); L. Olson, S. Tang, & P. Newacheck, *Children in the United States with Discontinuous Health Insurance*, New England Journal of Medicine, 353: 382-391 (2005); and G. Stevens, M. Seid, & N. Halfon, *Enrolling Vulnerable, Uninsured, but Eligible Children in Public Health Insurance: Association with Health Status and Primary Care Access*, Pediatrics, 117:751-759 (2006).
[5] John Holahan and Arunabh Ghosh, *The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003*, The Urban Institute, September 2004; available at www.urban.org/UploadedPDF/411089_HealthInsCoverage.pdf. See also Cindy Mann, Jocelyn Guyer, and Joan Alker, *A Success Story: Closing the Insurance Gap for America's Children Through Medicaid and SCHIP*, Georgetown University Health Policy Institute, Center for Children and Families, Issue Brief, July 2005; available at http://ccf.georgetown.edu/pdfs/success.pdf.
[6] Statehealthfacts.org based on the Census Bureau's Current Population Survey, March 2005 and 2006, downloaded January 19, 2006. The California Health Interview Survey data have a higher for the number of uninsured.
[7] Other bills have also been introduced that address SCHIP, such as that by Rep. Rahm Emmanuel (D-IL).
[8] Peter Harbage, Lisa Chan-Sawin and Clara Evans. *Funding California's SCHIP Coverage: What Will It Cost?* California HealthCare Foundation, Working Paper, February 2006.
[9] Major healthcare reform plans in California have called for increased federal support. Of these plans, only Governor Schwarzenegger has specified a plan for an immediate increase in Medi-Cal provider rates. For Speaker Fabian Núñez, Please See: Bill Ainsworth, "Boosting Medi-Cal viewed as first step," San Diego Union-Tribune, February 19, 2007. For Senate Republican Caucus, Please See: "The Cal-CARE Plan," January 2007. For Assembly Republican Caucus Plan, Please See: Assembly Republican Caucus Press Release, "Assembly Republican Health Care Reforms Will Maximize Choice, Reduce Costs, and Increase Access," March 14, 2007. Governor Arnold Schwarzenegger, Please See: Office of the Governor, "Governor's Health Care Reform Plan," January 2007. For Senate President Pro Tem Don Perata, Please See: "Health Care Q&A," December 2006. Also See: California Senate, Office of Research, "Comparison of Perata, Núñez, and Schwarzenegger Health Care Reform Proposals," January 11, 2007.

[10] States can disregard portions of family income when determining Medicaid and SCHIP eligibility. For example, disregards might be applied for work expenses, child care costs, or child support payments. For more information, see Authors, Center for Children and Families, Georgetown University Health Policy Institute. *States Affected by Proposals to Reduce SCHIP Coverage Options*. February 2007. Available at: http://ccf.georgetown.edu/schipdocs/schippop2-7.pdf

[11] For a full summary of the bill, see Senators John D. Rockefeller IV and Olympia Snowe, "Summary of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2007," April 26, 2007. Available at http://www.senate.gov/~rockefeller/news/Final%20Rockefeller-Snowe%20CHIP%20Reauthorization%20Bill%20Summary.doc

[12] Peter Harbage, Lisa Chan, and Clara Evans. *Funding California's SCHIP Coverage: What Will It Cost?* California HealthCare Foundation, Working Paper, February 2006.

[13] Projected enrollment as of September 2007. Please See: MRMIB, "2006 Estimate for the Healthy Families Program, Access for Infants and Mothers Program, and County Health Initiative Matching Fund Program for Fiscal Years 2006-2007 and 2007-2008," November 2006.

[14] The section 1115 of the Social Security Act applies to Title XXI, meaning that adults could be covered by Title XXI. In October 2005, Title XXI was changed to prohibit coverage of childless adults, per Title XXI, Sec. 2107(f). As original envisioned under the original law, parents can still be covered under Title XXI.

[15] Benjamin Sommers of Harvard examined Medicaid and SCHIP coverage retention over a year, and his analysis concluded that children enrolled in Medicaid or SCHIP were about 38 percent to 76 percent more likely to retain coverage when their parents also were covered. Please see: Benjamin Sommers, "Insuring children or insuring families: Do parental and sibling coverage lead to improved retention of children in Medicaid and CHIP?" Journal of Health Economics, in press, 2006. Research has shown that shown that insured children whose parents also are insured are more likely to retain their coverage longer and to receive needed preventative health care services than insured children whose parents lack coverage. Please See: Committee on the Consequences of Uninsurance, Institute of Medicine, Health Insurance Is a Family Matter, Washington, DC: National Academy Press, 2002.

[16] CHCF, *Healthy Families, Facts and Figures 2006.* January 2006. Available at: http://www.chcf.org/documents/policy/HealthyFamiliesFactsAndFigures2006.pdf

[17] 2005 California Health Interview Survey; available at: www.chis.ucla.edu

[18] Center for Children and Families, Georgetown University Health Policy Institute. *States Affected by Proposals to Reduce SCHIP Coverage Options*. February 2007. Available at: http://ccf.georgetown.edu/schipdocs/schippop2-7.pdf

[19] Projected enrollment as of June 30, 2007. Please See: MRMIB, "2006 Estimate for the Healthy Families Program, Access for Infants and Mothers Program, and County Health Initiative Matching Fund Program for Fiscal Years 2006-2007 and 2007-2008," November 2006.

[20] Senators John D. Rockefeller IV and Olympia Snowe, "Summary of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2007," April 26, 2007. Available at http://www.senate.gov/~rockefeller/news/Final%20Rockefeller-Snowe%20CHIP%20Reauthorization%20Bill%20Summary.doc

[21] UCLA Center for Health Policy Research "More than Half of California's Uninsured Children Eligible for Public Programs But Not Enrolled," October 2006.

[22] Center for Children and Families, Georgetown University Health Policy Institute. *Children's Eligibility for SCHIP*. October 2006

[23] Robert Pear. *Lacking Papers, Citizens Are Cut From Medicaid*. New York Times. March 12, 2007.

[24] California has always required a birth certificate be filed with a Healthy Families application. However, while California will enroll a child onto HFP for up to two months before receiving a copy of a birth certificate, the DRA rules prohibit enrollment until after an original birth certificate is received.

[25] Gestur Davidson et al, "Public program crowd-out of private coverage: What are the issues?" Robert Wood Johnson Foundation, June 2004. Amy Westpfahl Lutzky and Ian Hill, "Has the Jury Reached a Verdict? States Early Experiences with Crowd Out Under SCHIP," Urban Institute, June 2001. Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.

[26] Foundation for Taxpayer and Consumer Rights. *The California Patient Guide.* Available at: http://www.calpatientguide.org/index.html. These rules do not apply to the non-group market, as the primary concern is the crowd-out of employer dollars.

[27] Joan Alker, "Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity," Kaiser Commission on Medicaid and the Uninsured, October 2003, 4; available at www.kff.org/medicaid/upload/Serving-Low-Income-Families-Through-Premium-Assistance-A-Look-At-Recent-State-Activity-PDF.pdf

[28] "CHIP Reauthorization Act of 2007" (S. 1224), Section 701.

[29] "Credible coverage" is a very broad definition of health care coverage and generally encompasses most forms of health care. Section 2110(c) of the Social Security Act defines credible coverage as, "(2) CREDITABLE HEALTH COVERAGE.—The term "creditable health coverage" has the meaning given the term "creditable coverage" under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver)."

[30] David Bergman. *Perspectives on Reauthorization: SCHIP Directors Weigh In.* National Academy for State Health Policy. June 2005. Available at: http://www.allhealth.org/briefingmaterials/PerspectivesonReauthorizationSCHIPDirectors-538.pdf

[31] David Bergman. *Perspectives on Reauthorization: SCHIP Directors Weigh In.* National Academy for State Health Policy. June 2005. Available at: http://www.allhealth.org/briefingmaterials/PerspectivesonReauthorizationSCHIPDirectors-538.pdf

[32] The Alliance for Health Reform and Kaiser Commission on Medicaid and the Uninsured. *SCHIP: Let the Discussions Begin.* Webcast of Capitol Hill Briefing. February 9, 2007. Can be found at: http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2045

[33] Please See: Sara Rosenbaum and Colleen Sonosky, "Federal EPSDT Coverage Policy: An Analysis of State Medicaid Plans and State Medicaid Managed Care Contracts," Prepared for the Health Care Financing Administration December, 2000. According to the report, EPSDT includes:

- Screening services to detect physical and mental conditions. A screen is defined to consist of a comprehensive health and development history, an unclothed physical exam, appropriate immunizations in accordance with standards of the Advisory Committee on Immunization Practices, laboratory tests including lead blood level assessments, and health education.
- Vision services, including eyeglasses;
- Preventive, restorative and emergency dental services;
- Hearing services, including hearing aids; and
- Any 'other necessary health care, diagnostic services, treatment, and other Measures' that are described in §1905(a) of the Social Security Act (i.e., that fall within the federal definition of medical assistance) that are needed to 'correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.'"

[34] Lambrew, Jeanne M. "The State Children's Health Insurance Program: Past, Present, and Future," The Commonwealth Fund, January 2007; available at: http://www.cmwf.org/publications/publications_show.htm?doc_id=449518

[35] The Alliance for Health Reform and Kaiser Commission on Medicaid and the Uninsured. *SCHIP: Let the Discussions Begin.* Webcast of Capitol Hill Briefing. February 9, 2007. Can be found at: http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2045